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The harm threshold and parents' obligation to benefit their children

In an earlier paper *Harm is all you need?*,¹ I used examples from English law to claim that the harm threshold was an unsuitable mediator of the best interests test when deciding whether misguided parents should be overruled. I argued that it introduced pejorative language when we may wish to treat parents sympathetically, such as in cases where there is a dispute about withdrawal of medical treatment. I also argued that, in genuine dilemmas, the harm threshold was not less indeterminate than the best interests test, using the difficult cases from the family courts as examples, and suggesting that in the face of this indeterminacy it would not produce significantly different results from the best interests test. Foster,² McDougall³ and Wilkinson and Nair⁴ have produced commentaries that agree with my paper's most significant claim that the harm threshold is indeterminate, but dispute both the significance of this and other aspects of my claims. Both McDougall and Wilkinson and Nair are eager to support the harm threshold because they argue it gives appropriate weight to the interests of parents. Foster takes a different tack and essentially defends the usefulness of the harm threshold as it appears in current English law. In this paper I respond to these critics and extend my arguments to reject claims that there is a normatively compelling case for using the harm threshold to protect parental rights in clinical practice.

Harm in law or ethics?

English law contains a harm threshold and by using examples of the experience of the harm threshold in English law, I hoped to point out the difficulties of using this standard in ethical decisions. While most advocates of the harm threshold do not consider this legal corollary at all, I do note that Elliston's⁵ analysis of best interests favours an extension of the care approach—which utilises the harm threshold—to medical cases in English law. Foster's paper, which is critical of this idea, is an important gloss to her arguments. However, I do not wish simply to consider the place of the harm threshold in (English) medical law, but in medical ethics as well.

Distinguishing the harm threshold from the best interests test

I concede my critics' arguments that the harm threshold and the best interests test, in seeking to maximise benefits or avoid harms will not yield the same answer if exactly the same ranked index of harms and/or interests are used. Yet, harm is malleable, and competent adults dispute, among other examples, whether dying, being in pain, or living with a disability are harms. But there is no determinative list of harms. Rational choice theory stipulates that for an identical problem to be decided in an identical way, rational persons deciding the problem must share knowledge of all possible options, all possible outcomes of these options, the value that should be attached to each outcome and the probability of each possibility.⁶ My claim is that, in the absence of a public, ranked index of harms and/or interests that express these factors, the decisions reached by both the harm threshold and the best interests test are essentially dependent on the values of the user. One opaque test replaces another. In this sense then, best interests and the harm threshold *are* the same because they share indeterminacy. I do not think such a claim is controversial.

Foster notes that harm may be more easily perceived than best interests in some ethically complex cases, but as I attempted to demonstrate, it is as easy to disagree what a harm is. Such disagreement means that harm does not rest on a self-evident basis. Yet, potentially, such a claim underlies the arguments of proponents of the harm threshold i.e. in Diekema's claim that harm is better understood by clinicians than best interests⁷ or in Gillam's assertion that the harm threshold might be used where "best interests are uncertain or open to interpretation".⁸ These claims might make sense if harms are generally more easily identifiable than best interests in difficult cases, and it is this claim I set out to challenge (of course, a second reason to favour a harm threshold is if we may think that parental interests trump the interests of children. I will come to this claim in a moment). This is not to say that harm is of no use as a concept, and I find that both Foster and Wilkinson and Nair's approaches, in favouring a framework where a number of factors, including harms, can be taken into account in making a decision are essentially similar to my own argument that harm can be a useful intuition pump with which to determine best interests, but should not be the sole mediator of best interests.

Pejorative harm

I make a further claim in my paper that the harm threshold may be seen by judges to signal a negative evaluation of parental behaviour. This is, in general, an observation about the law, and is rather important when we consider the way legal judgments about children's harms and interests function. The family court can regularly be seen to address the wider public (not just the parents who are subject to the court's judgment) about standards of parental behaviour. Since several of my critics acknowledge that best interests have an aspirational value, this is important to reiterate, because if family court judgments are signals to the public about the correct way to treat children, then choosing the language of harms over best interests conveys an important public message. Moreover, the pejorative nature of harms may be salient in private discussions with parents. The language used by clinicians is important in determining the success of clinical alliances with parents; innately pejorative language used in a clinical setting may be perceived as confrontational and alienate parents in discussions.

Harm and parental rights

So far this response has trodden ground covered in *harm is all you need?* Yet Wilkinson and Nair and McDougall have, importantly, raised the issue parental rights. As Foster notes, the harm threshold places a higher bar for intervention than the best interests test (although this bar is notional, because we have no common index of ranked values to determine actual standards of intervention). Is a higher bar really what is needed to give the right weight to the interests of children and their parents in clinical decisions? To explore this, let us first consider McDougall's claim that the harm threshold is *normatively* correct whatever its empirical shortcomings. McDougall argues the harm threshold does indeed give appropriate weight to the interests of parents, because parents have a valid normative claim to make non-harmful decisions on behalf of their children. In other words, the harm threshold is correct because it is intimately connected to parental rights.

As McDougall notes, parental rights have staunch advocates within bioethics. Moreover, parental rights may be strongly supported by parents' themselves, and thus have a powerful pedigree if we wish to look for ethical principles in common morality. But these in themselves are not compelling reasons to support parental rights, since morality is not a popularity contest - and most advocates of a 'common morality' basis for ethics will concede that it does not suffice as a *sole* basis for deciding what is good.⁹ Now, McDougall suggests that the shortcomings of the harm threshold, should they be proved empirically, do not matter because the harm threshold is normatively correct. I find this use

of 'normative' slightly perplexing, because as Kant succinctly argued *ought implies can*,¹⁰ and I suggest there is a problem if a normative standard does not produce the results in practice that we claim in theory.

In fact McDougall offers only one source who explores a purely normative basis for parental rights (others make empirical claims).ⁱ Ross¹¹ argues that children are owed only a modified version of Kant's respect for persons because of their immaturity. Ross' argument is predicated on a relatively strong basis—that children have limited personhood—although this argument is let down by a weaker claim that the Kantian principle of respect for persons should vary depending on the relationships between people (while I do not subscribe to them, others make stronger arguments to make rights over children specific to parents).¹² Even if we accept Ross' argument we must note that this modified principle of respect for persons includes "a positive component which ... compels particular individuals to provide particular children with the goods, skills, liberties and opportunities necessary to become autonomous adults" (p47). Arguments that parental rights depend on benefitting children follow the writings of John Locke,¹³ and are widespread¹⁴ and, I suggest, compelling. Let us accept, then, that parents are under a moral compulsion to do good to their child. Accepting this, as Ross later argues, the primary reason to restrict interference with these goods (and thus employ a harm threshold) is on the basis that there is no shared conception of the good in a liberal society.

Medicine and the plurality of goods

I do not dispute that a plurality of goods exists. As Wilkinson and Nair note, it is open to question whether decisions to encourage one's children to learn a language, a musical instrument or a sport are good for the child, and they argue that medical goods should be a parental choice because this is *consistent* with granting parents' choice about other sorts of goods. Yet whether specifically medical goods fall into the ambit of this plurality of goods is debateable. Certainly Rawls, who as I explained in *Harm is all you need?* coined the concept of 'primary goods' on which Diekema's explanation of the harm threshold relies, suggests that there is an ordinal difference between the universal goods humans rely on to flourish, and the goods we might individualistically seek to satisfy our own desires thereafter. Because they can play such an important role in the flourishing of an individual, my suggestion is that the goods conferred by medical treatment are of a fundamentally different order to everyday goods like learning another language, a musical instrument or a sport, that a commitment to pluralism means we are happy to disagree about. This ordinal difference is reinforced because we have a great deal more information about what is and what is not medically beneficial than we do about the goods of French lessons and lacrosse. To be sure, the wild card of human biological difference and the fallibility of the practitioner means that we can rarely specify exact consequences that are completely free of risk. Yet in many cases we can make very highly informed judgements of medical benefits and harms, especially if we seek the expertise of practitioners who are experienced and skilful.

Currently we do not impose the primary goods encompassed by medicine on competent adults, because it is accepted that competent, informed adults may have visions of the good that, for one reason or another, reject health interventions. For instance, some adults refuse the influenza vaccine; others may refuse painkillers, others in malarial regions of the globe refuse malaria medication. In each case their vision of the good considers the risks of refusal worth running (any

ⁱ While McDougall may be a purist in normative matters, her main source, Salter, grounds parental rights in their knowledge of the child or the fact they bear the emotional and financial implications of the outcome of decisions made on the child's behalf, clearly empirical claims.

doubts about the validity of rationality and choice as the basis of ethics are shelved in this paper). Yet children are not competent to make their own decisions in these instances. Should they therefore be dependent on parental visions of health goods, and run these risks they do not themselves make?

As Wilkinson and Nair note, no decision is value free, and, where we impose our values, we must be sure these values are widely shared – Wilkinson and Nair use the term ‘reasonable’. While reasonableness is problematic because it supports contradictory ideas,ⁱⁱ we can use the concept to advance the argument that the paradigm from which the goods attributed to western medicine arise enjoys high levels of subscription among the populations of liberal societies, who generally accept that medical goods are goods in a wider, morally important sense. This widespread acceptability means that, arguably, these concepts pass Wilkinson and Nair’s test of reasonableness. Since medical goods can therefore be reasonably be viewed as goods, if we accept Ross’ argument that parental rights involve an obligation on the part of parents to provide their child such goods, it seems there is a good case to argue that parents are under a normative obligation to agree to medical treatment that benefits their child.

Allowing parental discretion

Wilkinson and Nair seem, substantially, to subscribe to this view. Wilkinson’s example of parents who refused a vitamin K injection for their child, on the basis of an apparently implacable distrust of medicine and thus exposing their child to a 1 in 10 000 risk of catastrophic harm, is pertinent here. For Wilkinson does not question the benefit of giving a newborn infant vitamin K, nor does he doubt that to advocate for this benefit is his duty as a doctor. Nevertheless, he presents a number of reasons for avoiding coercive measures to compel parents to fulfil this obligation to benefit: medical and value uncertainty, the negative impact of interference on the parents’ interests and the need to be consistent with the broader principle of parental discretion about what is good in other areas.

Of the reasons Wilkinson and Nair give, I have already suggested that the degree of value uncertainty manifest in refusing of health benefits for children does not amount to a reasonable difference in values, and this seems especially sustainable if this the basis this refusal is a parental belief system that denies the reality medical benefits in the face of empirical evidence. I have also argued that it is mistaken to seek consistency with other areas of parental discretion in allowing refusal of medical goods, because there is an ordinal difference in medical and many other goods. Wilkinson and Nair’s final point, that both the parents and the child have interests that must somehow be brought to equipoise is, however, valid—although this fails to convincingly press the case that the harm threshold represents the correct balance of interests in all cases, since the variable distribution of harms and benefits will mean that in some cases the child might benefit substantially at minimal cost to the parents’ interests.ⁱⁱⁱ

In this case, while I think Wilkinson was correct not to seek a court order to overrule the parents’ refusal, the arguments Wilkinson and Nair offer are not the best ones to support this inaction. The implacable refusal of the parents for what amounted to fairly shallow reasons suggests the harm

ⁱⁱ Parental rights, the goods of medicine and the duty to protect vulnerable children all appear to enjoy widespread agreement and thus be ‘reasonable’, but different weighting of each element may result in different responses. In such a situation we must look to the quality of the arguments that support each idea, although the length of this paper means I must shelve a lengthy discussion of each concept.

ⁱⁱⁱ It also raises some interesting questions about the degree of disadvantage a child’s interests should suffer in an equal balance with the interests of superior number of parents and other interest holders, since the latter’s aggregate interests will often be greater.

that the parents would have endured if they were overruled would be minor, and such harms would not outweigh the catastrophic harm to their child that they risked, however remote those risks. Further, my own experience of parents whose children have suffered catastrophic repercussions of their refusal to consent to basic prophylactic health interventions is that such repercussions have a devastating effect on the wellbeing of the parents. It seems one may be *protecting* parental interests in this case by overruling them.

I suggest that the best reason to respect these sorts of parental refusals in practice does not rest on the normative desirability of parental rights, but upon a desire to maintain parental engagement and thus be in a position to benefit the child if less remote risks arise (as they did in Wilkinson's example, when the child subsequently required antibiotics). There are, nevertheless, other, more positive reasons to respect parental opinions. Parental rights, correctly constituted, may support their ultimate authority in some restricted circumstances where the child has very marginal interests e.g. termination of pregnancy. Further, parents sometimes have strong claims to authority where they have greater knowledge of their child than clinicians borne of their intimacy with the child and their familiarity with their child's clinical path.¹⁵ To me, Wilkinson's example demonstrates that greater issues are at stake in proposing that a harm threshold is the correct *normative* level for allowing interference with parental decisions. By suggesting laudable practice rests upon a sanctification of parental rights, where practitioners relinquish their knowledge, their expertise and above all their duty to improve the health of children, the harm threshold represents an impoverished vision of children's medicine.

Conclusion

In this response I have considered the main points made by three critiques of my earlier paper. I have acknowledged that, if we were able to agree a public index of harms and interests we might distinguish the harm threshold from the best interests test, but maintain that in the absence of such an index, both tests are similarly indeterminate. I have suggested that the pejorative nature of 'harm' may have an impact on its use in clinical settings as well as legal ones. I have also considered the nature of parental rights, and argued that most conceptions of parental rights suggest a parental obligation to do good to their child. While many goods must be understood pluralistically, I suggest that the health benefits of medicine are antecedent to this plurality of goods, and can be understood as primary goods necessary for individual flourishing. By dint of this primary nature, parents have an obligation to promote their child's medical goods. While normatively desirable, we do not enforce this obligation in some cases because the harms to the parent of enforcing this obligation may outweigh the benefits to the child. In other cases we avoid compelling parents to make good this obligation for pragmatic reasons, rather than normative ones. In these cases the ultimate goal of our inaction must be to maintain engagement with parents in order to promote benefits to the child. Ultimately, I suggest that the harm threshold represents a flawed vision of children's medicine.

¹ Birchley G. (2015) *Harm is all you need? Best interests and disputes about parental decision-making* J Med Ethics.

² Foster, C. (2015) *Harm: as indeterminate as 'best interests', but useful for triage* J Med Ethics.

³ McDougall, R. (2015) *Indeterminacy and the normative basis of the harm threshold for overriding parental decisions: a response to Birchley* J Med Ethics.

⁴ Wilkinson, D., Nair, T. (2015) *Harm isn't all you need: Parental discretion and medical decisions for a child* J Med Ethics.

⁵ Elliston S. (2007) *The Best Interests of the Child in Healthcare*, London: Routledge Cavendish.

⁶ Parker S. (1994) *The Best Interests of the Child - Principles and Problems*. IJLPF 8: 26-41.

⁷ Diekema DS. *Parental Refusals of Medical Treatment: The Harm Principle As Threshold for State Intervention* Theor Med Bioeth 2004;25(4):243-64.

⁸ Gillam L. *Children's bioethics and the zone of parental discretion* Monash Bioeth Rev 2010;29(2):09.1-09.3

⁹ Strong C. (2010) *Theoretical and practical problems with wide reflective equilibrium in bioethics* Theor Med Bioeth 31: 123-140

¹⁰ Kant I. (1991) *Kant's Political Writings*, 2nd Edition, Cambridge: Cambridge University Press. 62-92.

¹¹ Ross LF. (1998) *Children, Families, and Health Care Decision Making*, Oxford: Oxford University Press. 44-50.

¹² Engelhardt HT. (1996) *The Foundations of Bioethics*, Second Edition, Oxford: Oxford University Press. 135-189.

¹³ Locke, J. (1993), *Of Paternal Power, from 'The Second Treatise of Government'* (first published 1689). In: *Political Writings*. D. Wootton (ed) London: Penguin Books. 286-299.

¹⁴ Munthe, C., Hartvigsson, T. (2012) *The best interests of children and the basis of family policy: The issue of reproductive caring units* In: Cutas, D. and Chan, S. (eds) *Families – Beyond the Nuclear Ideal*. London: Bloomsbury Academic. 49-63.

¹⁵ Birchley G. (2015) *'You Don't Need Proof When You've Got Instinct!': Gut Feelings and Some Limits to Parental Authority* In: Huxtable, R. and Meulen, R.T. (eds) *The Voices and Rooms of European Bioethics*. London: Routledge. 120-135.